

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K033		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 05/21/2015	
NAME OF PROVIDER OR SUPPLIER ANOINTED TOUCH HOME HEALTH LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2021 E 52ND ST STE 100 A-E INDIANAPOLIS, IN 46205			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{G 000}	<p>INITIAL COMMENTS</p> <p>This was a revisit for an extended federal home health agency complaint survey conducted on 4-9, 4-10, 4-13, 4-14, 4-14 and 4-16-15.</p> <p>Complaint #: IN00153329; Substantiated - Federal deficiencies related to the allegation are cited. Unrelated deficiencies are cited.</p> <p>Survey date: 5-21-2015</p> <p>Complaint #: IN 00153329</p> <p>Facility #: 011457</p> <p>Medicaid Vendor: 200891860</p> <p>Current Census: 17 Skilled patients 24 Home Health Aide only patients 41 Total</p> <p>Five (5) condition level deficiencies and twenty (20) standard level deficiencies were found corrected during this survey.</p> <p>Anointed Touch Home Health, LLC, was found to be in compliance with 42 CFR 484 for home health agencies.</p> <p>Anointed Touch Home Health, LLC, is precluded from providing a home health aide training and competency evaluation program for a period of 2 years beginning 4-16-2015 to 4-16-17 for having been found out of compliance with the Conditions of Participation 42 CFR 484.10 Patients Rights; 42 CFR 484.14 Organization, Services, and Administration; 42 CFR 484.16 Group of Professional Personnel; 42 CFR 484.36 Home</p>			{G 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{G 000}	Continued From page 1 Health Aide Services, and 42 CFR 484.52 Evaluation of the Agency's Program.	{G 000}			
{G 173}	QR: JE 5/26/15 484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by:	{G 173}			